NC Mental Health Planning and Advisory Council

Meeting Minutes of November 2, 2012

10 a.m. - 3 p.m.

630 Palmer Drive, Taylor Building, Dorothea Dix Campus, Raleigh, NC

Present: Marc Jacques, Kent Earnhardt, Vicki Smith, Eva Eastwood, Bruce Spangler, Damie Jackson-Diop, Gail Cormier, John Deir, Mary Edwards, Jim Swain (Gina Price), Dick Brunstetter, Mary Lloyd (phone), Gwen Bercoldi (Mary Reca Todd), Martin Pharr, Terri Shelton (phone), Danielle McConaga, Trish Hahn, John Sullivan
Guests: Brad Trotter, Rob Lineberger, Vince Newton
Staff: Walt Caison, Emery Cowan, Maria Fernandez, Susan Robinson

- The meeting was convened. Introductions and welcomes were exchanged.
- The minutes were reviewed and approved as amended.
- The proposed agenda was reviewed with minor changes in the order of items to be discussed.
- The 2013 meeting dates and tentative focus and outcomes of the meetings were reviewed and approved. It was noted that due to pending changes in the plan requirements and format the timing of the meetings may need to be adjusted. Federal guidance will be forthcoming on this, though staff do not know when states will be informed of final format and timelines for this new two-year plan.

  March 1 - work on SFY 2014-15 Plan for public review & comment
  May 3 - work on SFY 2014-15 Plan for submission Sept 1 – DMH updates &DOJ settlement
  August 2 - work on SFY2012-13 Report - youth/young adults in transition speaking about their goals, experience accessing services, completing school, barriers accessing VR due to substance use disorders
  November 1 - work on SFY2012-13 Report for submission Dec 1

DHHS Priorities for the Division of MHDDSAS

Susan provided a brief overview of the five DHHS Priorities being addressed in the Division of MHDDSAS's Strategic Plan for SFY2013. One of these includes Bring NC Kids Back Home, which addresses the significant increase in children and youth with serious emotional disturbance who are living in out of home treatment settings, in particular, Psychiatric Residential Treatment Facility (PRTF). There are more than 300 in these treatment settings, part of those settings are within a 40 mile radius of NC state line. These are considered by Medicaid to be 'in state' enrolled providers. The divisions of Medical Assistance and MHDDSAS are working together with other stakeholders to map out a strategy for assessing child needs and identifying/creating effective community based treatment services to meet these needs.

<u>Discussion and Questions regarding the DHHS priorities included the following:</u>

- What more do we know about the youth in out of state treatment setting?
- What do the youth tell us about their interests and needs?
- How are the youth involved in their plan for next steps of those who are living in out of state treatment settings now?

- Are the natural supports enough or do they need to be developed for these youth?
- Lucy indicates as well as Vicki confirms that of the 20 they know about, who need treatment services that are not available in state at this time. They each have very complex treatment needs.
- Damie, NC Youth MOVE, and Gail, NC Families United, discussed the RENEW model for youth who are in these treatment settings.

- Jim thought that perhaps VR and DMH could do a pilot for youth/young adults 16-26 (not 14 though DPI begins there.) He and Alice Farrar, a colleague in VR who works primarily with youth/young adults, were just speaking of the need to address these needs better together. For some of the youth are not ready to stop using SA and get treatment. The opportunity is exciting. Damie and Jim/Gina and Alice will follow-up on next steps for what is possible, especially, through the window of opportunity to increase comfort level and expertise in working with youth on the fringe created by the DOJ settlement.

- RENEW is not a system coming to the table, but as a framework that provides future planning for success with youth/young adults. RENEW promotes self-directed, youth guided planning. Mecklenburg – 'on-ramp and the relatives' (targets youth who are homeless) has three new RENEW counselors; the counselor youth ratio is 1:15; with the three staff, the program can serve up to 30-45 youth at a time. All the work in youth leadership development and RENEW is completed thru support of the MHBG. Members discussed how to access RENEW training (contact: Damie or Gail). Ways in which NAMI and NC Youth MOVE can work together with youth/families will be explored. Training and targeted implementation of RENEW in communities could be one step. NCFU and NC Youth MOVE use blended funding to serve more youth. Youth/young adults who meet criteria to be a RENEW mentor are certified and paid just as professionals. A new bibliography and reference list will be shared with the Council (Gail/Damie will send.)

- Damie acknowledged that in recent work together that both Marc and Jennifer made sure that youth were present to provide information.
  It was suggested that youth come

Deaf Services – Current Status & Challenges

Brad Trotter, Deaf Services Coordinator, Best Practice Team, provided an overview of the types of services provided, the number and need for behavioral health treatment services for children and youth with serious mental health treatment services who are deaf or hearing impaired. Brad stated that the DMHDDSAS has been able to sustain funding for regional deaf consultants; they are located with the LME/MCOs regionally. Their expertise and work are critical to ensuring access to behavioral treatment services for those in need.

Brad stated that there are six children who are deaf that he knows of who are in Florida who are receiving treatment. He has been working with Medicaid to secure in state treatment services.

Brad indicated there is a barrier that has become more about the cost of the educational programs for the specialized treatment needs. Brad recently met with the Eastern School for the Deaf who is interested in working with DMHDDSAS to come up with solutions that are effective, accessible and cost-wise.

Vicki stated that DRNC filed an Office of Client Rights (OCR) complaint with Office of State Education Resources Services (OSERS) on behalf of these children. Brad acknowledged such support in meeting the children's needs is important. There are so many challenges that seem to be barriers to addressing the needs of these children.

A Council member indicated that deaf services began in NC, because of an OCR complaint due to a 90 year old man who had been at Cherry Hospital for 60 yrs who was not mentally ill; he was deaf.

Deaf services regional consultants have been sustained in the system with and thru the MCOs contract providers. This is quite a fete to have kept staff and programming through all of the changes in the system; these include: Smoky Mtn Center, Coastal Care (eastern state), and Alliance Behavioral Health Care (central). Wake County is still trying to figure out where the deaf treatment services staff will be housed and how their work scopes will be divided among the counties; many are going to UNC-CH. In the next few months, these positions will be settled as part of the provider network.

Last year NC DMHDDSAS served over 700 children who are deaf/hearing impaired and who experienced MH/SA treatment needs. Most of the behavioral health treatment services are provided by LCSWs, MSWs, psychiatrists, and psychologists. Beginning to provide an encrypted video conferencing thru Polycom systems, not computers or regular lap tops to ensure confidentially secure treatment services.

<u>Discussions and Questions:</u>

- Members discussed the effectiveness of tele-psychiatry and its availability. Studies are being done for those who are deaf or hearing impaired. Research with hearing able people, telepsychiatry is very effective and a viable option to access treatment and clinical consultation. Choice is certainly provided as possible, though a choice for a signing vs. non-signing therapist is not always available.

- John asked about a step-down from a PRTF located in FL to here in NC. Brad and John will work together after this meeting to help address treatment needs and transfer to appropriate treatment regarding two families John is working with presently. The preferred treatment if in an out of home placement is in a treatment family setting and helping to train the signing therapeutic parents. The costs associated with interpreter services are high; it is really expensive.

- RHA Behavioral Health has really stepped up and has a serious commitment to serving youth and families who are deaf. Hopefully, a provider like this will be found for Wake county children who need services.

- Although there are challenges, Brad is very hopeful as is the deaf community at large regarding appropriate, effective culturally and linguistically sensitive: he is more hopeful than have been in 10

years. Work with Medicaid to see viable options to help promote affordable treatment and a responsive service system.

- Assessment, therapy, specialized services (enhanced e.g. SAIOP –substance abuse intensive outpatient program – deaf clients will not get those services from enrolled ASL (American Sign Language) clinicians, how is that going to happen? How are these services going to happen? How will interpreter services be provided SAIOP, as an example or for other services as a whole?

- DMA says interpreter services have been built into the cost of providing services. If a provider is receiving reimbursement for the treatment service, an interpreter will bill $70/hr, and training is needed to support the treatment services. There is a need to find a way to pay for the cost of interpreter services, raise awareness regarding the need and the lack of access; Brad is working with DMA regarding MCO contracts in to meet ADA compliance. A process for grievance of denials and appeals for access to treatment is needed.

- There is a plan to work on these issues, especially to ensure that the DMA/MCO/provider – has a way to provide Medicaid reimbursement for treatment services.

- In the past, attempts were made for different ways to provide access to interpreters in the community. First, DMHDDSAS paid LMEs based on expenditure of interpreting services. At this time, this is the best way DMHDDSAS can ensure interpreters are provided; the billing for payment is completed through the state. This is a working system. There is a real need for others to get involved in this. A master plan will be developed for providing interpreter services. There are at least 20 states that have this service defined under Medicaid. Perhaps NC will be the next one to do so.

- State facilities are under Division of State Operated Facilities (DSOF.) Currently there is a deaf services program at Broughton and this works well with the Morganton School for Deaf. If there are issues that come up with facilities, DSOF handles these.

<u>Challenges and Needs for Interpreting Services</u>:

- Most often the common response is “we need to have an interpreter to help with treatment,” however the most effective treatment is when service are providers are also interpreters.

- What is the average length of time between when the interpreter is called and when they arrive when an individual presents for services. Good question, tries to get there as soon as possible; sometimes it can be an hour or so before the interpreter arrives.

- VRI – video remote interpreting - - VR is a way to provide treatment with signing (ASL); this service uses computer technology. This is a much needed service. Hopefully, computer technology will help increase access.

- There is a need for treatment providers who are also interpreters; we need to double the number of interpreters.

- The first plan was written in 1992, NC population was 5,000,000, and it has now doubled. Providers are very busy now and can't respond to all of the needs.

- There is a MH Advisory Council for the Deaf. Soon, Ken Edminster, Housing Specialists with Best Practice Team, will be talking with this advisory council.

- Gwen indicated MaryReca Todd has been working with housing options for choice of where individuals want to live. With a housing option to have deaf peers nearby, will increase

SFY 2012 Accomplishments, Challenges, Significant Achievements, Council Recommendations and Priorities

Susan reviewed the outline for the SFY 2012 report. The Council reviewed the data, trends, measures and indicators, and set targets. Suggestions to modify some of the indicators for next SFY. In addition priority tasks the Council would like to take on in 2013 were identified. All are listed below.

SFY 2012 Report Highlights

Accomplishments/Significant Achievements (Strengths)

- Adult MH-Strengths –geriatric teams
- 600+ certified peer supports specialists in place
- 290 Family Partners trained across NC culturally diverse
- Youth Leaders have been trained and are active
- NC Youth MOVE national awards – SAMHSA /CMHS Rock Star and Voice, individuals awards

Challenges (Needs & Opportunities)

- AMH - Need to keep funding for geriatric teams and MH services for elders are needs
- CMH-youth in transition need access to appropriate treatment services
- CMH-establish and fund capacity for Family Partners and for RENEW
- CMH-increase support of youth leadership that is completed statewide (reduce impact of stigma) –promote strengths, promote better understanding of the youth culture and needs.
- AMH – lack of services for personal care services, esp. for those who will re-enter the community from IMDs
- Lack of Case management services - although high needs are addressed, others need this service too
- Lack of clarity between care coordination and case management (Walt is working DMA on this)
- Loss of lower level support (e.g. EBP PSR models) and preventive services that reduce ability to stay in housing, and to stay out of the hospital.

Council Priorities for SFY 2013 & SFY 2014 – tasks the Council wants to do or promote in SFY 2013

- ✓ Increase collaboration among family/advocate organizations, find common ground between child/youth and adult advocates/consumers (e.g. NAMI Smarts, parenting education, work with schools and community colleges, wellness messages, awareness messages, self-care, etc.).

- ✓ Articulate and establish a recovery oriented SOC (e.g. CT policy 183 – the goal is to get better.)

- ✓ Develop fact sheets/promote facts thru cost-benefit of lower level supportive & preventive services

- ✓ Demonstrate cost-benefit of lower level supportive & preventive services for all ages and populations. Investment in prevention costs less later (MH impacts health, build resilience, promote recovery.

The Council engaged in a working networking information exchange lunch.

DOJ Settlement Overview & Related Services/Supports Update

Vicki stated that Beth Melcher and Best Practice Team staff have been working hard to bring the vision of long term plan that the DOJ settlement supports possible. It is an opportunity for addressing the long term vision we all have for individuals living in the community with supports and treatment needed. It will not address immediate crises NC is facing. An analogy offered was to consider NC building levies for long term care and long term supports.

Emery Cowan, Supported Employment Specialist, with Best Practice Team, and Walt Caison, Best Practice Team Leader, provided an overview of services and supports to address the gaps and prepare for helping people live successfully in the community 1) housing and 'in-reach' (as needed thru Money Follows the Person), and 2) developing community wrap around services. Emery provided details and ways the Council can be engaged in shaping the system of services needed.

<u>Discussion and questions included:</u>

- How will choice be offered and provided?
- Will there be a focus on 65 and older and how?
    - There is no discrimination of age. Choice is offered to all who are living in the current settings.
- How will transportation be provided and handled?
- Who is looking at safety wellness and sensitivity to be healthy and successful (e.g. not near substance abuse dealers, etc.)
- What is the funding like for these housing sites and the arrangements? How will this all be handled? Who does this?
    - There will be key staff to help: Assessment, Transition coordinators, Housing specialists
- It was suggested that different titles for the roles staff play that connect with consumer needs and reduce stigma, such as, home finders, housing transition coordinators.
- Integration means >50% with all living in community together.

- Evidenced Based Practices (EBPs) for service development are being researched – the aim is to have fidelity to the model, having practice and policy align.
- Outcomes will be developed and measures identified so meeting objectives is clear.
- Services for ACT and for Supported Employment (SE) will be revised to align with EBPs for each.
- Certified Peer support specialists will be in each service and support – a way to employ peer support specialists
- DOJ has an independent Special Adviser, Marilou Sutters and Jessica Bradley, ADA compliance expert. Both have an eye on re: recovery focus and choice.
- It sounds like this work is addressing changing the culture toward recovery.
- It was agreed with the idea of having a housing panel to see how housing is being coordinated. Gwen indicated that the Housing Finance Agency is involved and helping to identify housing available for access to those transitions into the community.
- Transitions to community living – Jessica Keith will be outlining an implementation plan that will be posted.
- Service definitions are being revised. Current services aren't written to fidelity or able to be monitored to fidelity and compliance to the practice model, though the services do exist. There is a goal of Jan 1st for implementation after the DMA review process is completed.
- Approximately 3000 people will be transitioned in 8 years.
- A "smart thing to do" is it possible to establish a special assistance in home program – this could follow the person.
- LONG term supported employment is an ongoing need the Council has identified; this is the opportunity to implement.
- There is a concern that the IPS model will lead to better employment. IPS, Business led model, Small business model – all must be considered for best option.

Waiver Implementation Update

Lucy Dorsey, System of Care Coordinator (SOC) in Sandhills/Guilford LME/MCO, provided an update on their status. Sandhills delayed transition date from July 1, to Oct 1 to now Dec 1. There are challenges regarding MH/SA Case management.

Meeting Wrap-Up

Marc reviewed the Council's comments and priorities that need to be included in the revised draft of the report. It was noted that many of the priorities and outcomes the Council has identified are likely to carry forward into the next year's plan. Most agreed with this since changes were so new in addressing the DHHS priorities. NC's has certainly addressed the MHBG Plan's criteria in implementing the DMHDDSAS strategic plan.

Meeting was adjourned by Marc; all were thanked for their lively discussion and active work on the plan and the report this year. The next meeting will be in 2013.

Thank you! Travel Safely! Happy Holidays!

SFY 2012-2013 MH Block Grant Performance Indicators & National Outcome Measures

- Increased Access to Services
- Reduced Utilization of Psychiatric Inpatient Beds – 30 days
- Reduced Utilization of Psychiatric Inpatient Beds -180 days
- Persons Receiving Evidenced-Based Practices – Assertive Community Treatment
- Persons Receiving Evidence-Based Practices – Children/Youth
- Client Perception of Care
- Adult-Increased/Retained Employment
- Child – Return to/Stay in School
- Decreased Criminal Justice Involvement
- Adult – Increased Stability in Housing
- Increased Social Supports/Social Connectedness
- Improved Level of Functioning
- Access to Services
- Decreased Use of Adult Admission Bed Days
- Decreased Use of Adult Long-Term Bed Days
- Appropriateness of Care (not measured for children/youth)
- Services in Rural Areas
- Services in Rural Areas
- Satisfaction with Care

TODAY's Meeting Notes - Topics/Speakers & Tasks	TODAY's Action Plan Next Steps - (what, who, by when)
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